Reset

South Carolina Department of Social Services

MEDICAL REPORT FORM FOR PROSPECTIVE FOSTER/ADOPTIVE PARENT

Patient's Name: _____

I hereby authorize _____ to release the medical information contained on this form
(Licensed Medical Practitioner)

to the _____ for the purpose of assessing my family for foster/adoptive placement.
(County/MTS/Adoption Office)

Patient's Signature: _____ Date: _____

I. Medical History

Check any of the following conditions the patient has or has had in the past and provide comments.

- ❑ Mental Illness
- ❑ Impaired Hearing
- ❑ Impaired Sight
- ❑ Any Surgical Operations
- ❑ Depression
- ❑ Orthopedic Defects
- ❑ Chemical Dependence
- ❑ Cancer
- ❑ Hypertension
- ❑ Allergies
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Other Medical Condition
- ❑ Ulcers
- ❑ Heart Disease
- ❑ Neurosis
- ❑ Epilepsy
- ❑ STD
- ❑ Communicable Diseases (HIV+, Hepatitis B, other)

Comments: _____

II. Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____

Eyes: _____ TB Test: (Date and Finding) _____

Ear, Nose, Throat: _____ Cholesterol Reading: _____

Heart: _____ Lungs: _____

Please complete front and back of form

III. General Health and Physical Condition

What medication(s) is/are patient taking? _____

What medication(s) has/have been prescribed in the recent past? _____

Is there any organic or functional disorder that would affect the patient's life expectancy or ability to function as a parent? ❑ Yes ❑ No
If yes, please elaborate: _____

How long have you known the patient? _____

From a medical viewpoint, would you recommend this patient as a foster parent? ❑ Yes ❑ No

From a medical viewpoint, would you recommend this patient as an adoptive parent? ❑ Yes ❑ No

If no, please elaborate: _____

Please use this space for any additional comments: _____

Date Examined: _____ Licensed Medical Practitioner's Signature: _____

Address of Licensed Medical Practitioner: _____

Telephone: _____ Typed Name of Licensed Medical Practitioner: _____

Please return form to: _____